Health financing policy: a guide for decision-makers

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Division of Country Health Systems

ABSTRACT

This paper elaborates an approach to health financing policy that countries can adapt to their own national context. This entails: (1) specification of a set of health finance policy objectives, grounded in the core values espoused by WHO; (2) a conceptual framework for analysing the organization and functions of the health financing system; and (3) recognition of the way in which key contextual factors, particularly fiscal constraints, affect a country's ability to attain policy objectives or implement certain types of reforms. Because of the great diversity of national contexts, there is no "blueprint" – no particular model or system of financing – that is appropriate for all countries. Hence, while the approach is fundamentally grounded in a common set of values and objectives, it permits analysis and recommendations that are country-specific and realistic. Key messages for decision-makers are to identify and address the harmful consequences of fragmentation in financing arrangements, and to ensure that the instruments of health financing policy are consistently aligned with the objectives.

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Purpose of the paper and overview

1. The countries of WHO's European Region, like all countries in the world, face difficult challenges and choices in financing their health systems. New medicines and other technological developments, rising expectations and aging populations fuel increased demand and hence put upward pressure on system costs. Concurrently, macroeconomic, demographic, and fiscal constraints limit the extent to which governments can simply allocate more public revenues for health. The combination of upward pressure on costs and limitations on the ability of governments to increase spending forces countries to consider reforms to the way that their health systems are financed.

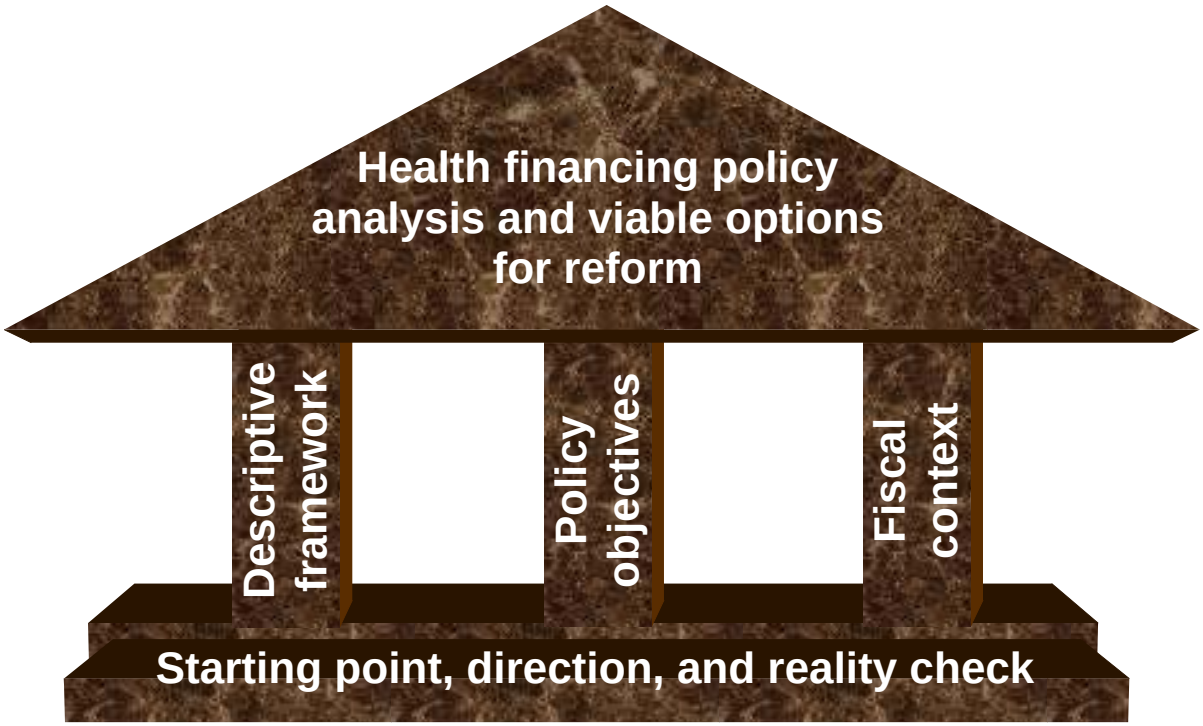
2. There is no single answer to the question of how to finance health systems. Not only do the specific challenges faced by countries differ, each country already has a system of health financing that has developed over a period of time. In many countries of the European Region, the basic features of national health financing systems have been in place for decades (in some cases, more than 50 or even 100 years) and are a part of national cultural identity (e.g. the United Kingdom's National Health Service, or Germany's social health insurance system) *(1)*. In such countries, debates on reform of the financing system have more to do with changes at the margin rather than wholesale organizational change. In many other countries of the Region, however, particularly those directly involved in the transitional process that began in 1990, health financing systems can be more narrowly considered as a set of technical arrangements without the strong cultural/historical overlay. And in many of these countries, more fundamental health financing reforms have been implemented or are under consideration.

3. The WHO Regional Office for Europe must be able to support each country in the Region in responding to its particular challenges and priorities in its own context. This requires having an approach that is technically sound and solidly grounded in the shared values and goals of WHO and its Member States, yet flexible enough to be adapted to the diverse systems and contexts of the Region, thereby making it possible to provide useful analysis and concrete recommendations and advice. This is what we propose here: a way for countries to approach health financing policy in their own national context.

Three pillars of health financing policy

4. Our approach is built on three pillars (Fig. 1). We begin with a set of objectives for health finance policy that are applicable to all countries, grounded in the core values espoused by WHO *(2)* and derived from the framework given in *The world health report 2000 (3)*. These provide the ***direction*** in which reforms should try to push the system. As such, the proposed policy objectives also serve as criteria against which the effects of reforms to health financing systems can be assessed. The second pillar is a conceptual framework for analysing the organization of national health financing systems. This is used to describe the functions and policies associated with all health financing systems, irrespective of the model or label used to classify them. Use of such a descriptive framework is essential for tailoring analysis to the consideration of specific reforms in specific country contexts, because the way in which a health financing system is currently organized provides the ***starting point*** from which any reform begins. The third pillar consists of a recognition and analysis of how key contextual factors, particularly fiscal constraints, limit the extent to which a country can sustain achievement of the policy objectives, and may limit the range of policy options that can be considered. This pillar thus allows a ***realistic analysis*** to be made of what is feasible to implement and what can be attained.

Fig. 1. Three pillars for analyzing health financing policy



5. The objectives of health financing policy that we propose are derived specifically from the overall health system performance *goals* described in *The world health report 2000,*[1] by considering the goals that health financing arrangements influence. On this basis, we derive the following set of health financing policy objectives:

- financing policy objectives that are essentially identical to broad health system goals:
  - promoting universal protection against financial risk;
  - promoting a more equitable distribution of the burden of funding the system;
- financing policy objectives that are instrumental, intermediate objectives to the broad health system goals:
  - promoting equitable use and provision of services relative to the need for such services;
  - improving transparency and accountability of the system to the population;
  - promoting quality and efficiency in service delivery; and
  - improving efficiency in the administration of the health financing system.

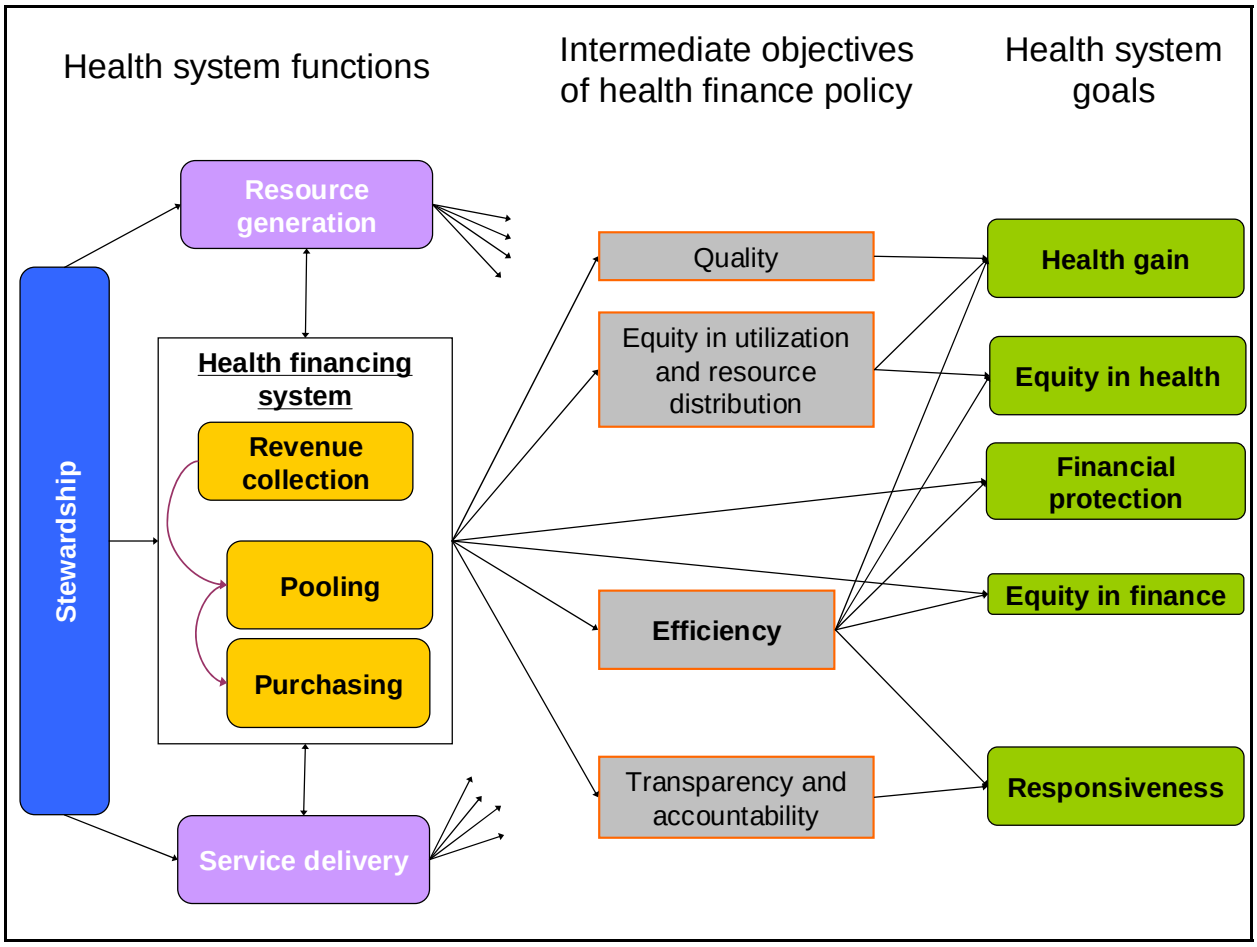
6. The descriptive framework is also grounded in *The world health report 2000*, which identified health financing as one of the four functions of the health system.[2] The *health financing system* consists of specific subfunctions and policies – revenue collection, pooling of funds, purchasing of services, and policy on benefit entitlements and patient cost-sharing obligations. The connection between health financing, other system functions, the health finance policy objectives and overall health system goals is

[1] These goals are: to improve the level and distribution of health of the population; to improve the level and distribution of responsiveness of the health system to the expectations (other than health) of the population; to improve the "fairness" of financial contributions to the health system made by the population; and to improve overall system efficiency, i.e. maximizing attainment of the previous goals within the limits of available resources.

[2] The other functions are stewardship, resource generation (investment in human and physical capital and inputs), and service delivery (personal health care and population-based health services).

depicted in Fig. 2. One important concept illustrated here is that the health financing system does not act alone in affecting intermediate objectives and final goals; coordinated policy and implementation across the health system functions is essential to achieving desired results.

Fig. 2. Links of health financing system to policy objectives, other system functions and overall system goals



First pillar: proposed objectives for health financing policy

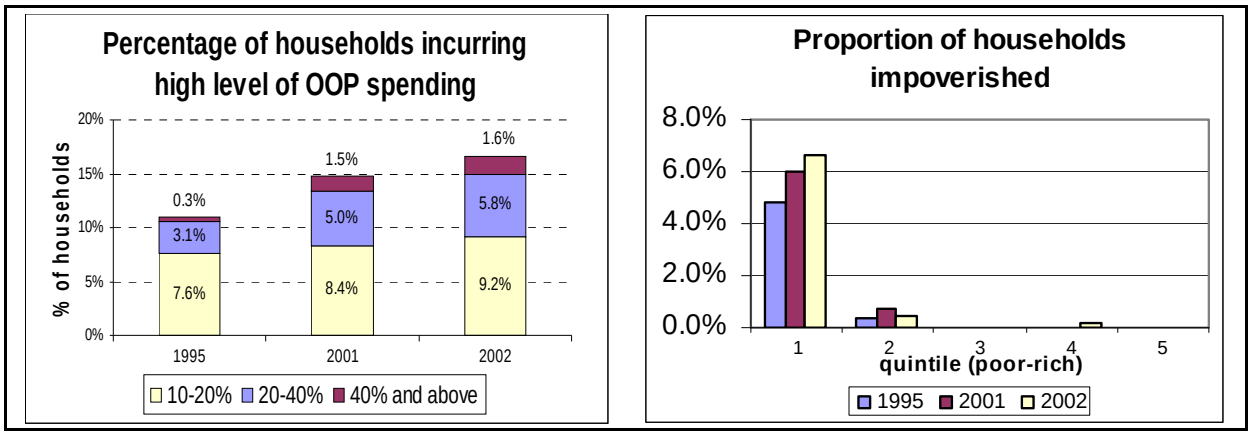
7. The health finance policy objectives serve as criteria that we use to assess the attainment and performance of health financing systems and the effects of reforms. While the specific ways that countries operationalize these objectives vary, as does the relative emphasis they give to each, we believe that they are universally applicable and independent of the labels or models by which their health financing arrangements are identified. Moreover, these objectives can be translated into concrete measures that in turn can be the target for practical policy interventions.

8. Protection against the financial risk of ill health, or ***financial protection***, is a goal that can be summarized simply as follows: people should not become poor as a result of using health care, nor should they be forced to choose between their physical (and mental) health and their economic well-being. Indeed, this issue reflects one of the most direct associations between health and welfare: the extent to which people become impoverished by health expenditures, or conversely, the effectiveness of the health financing system in protecting people against the risk of becoming poor, while enabling them to make use of services. Standard measures of this objective exist *(4)* and can be produced for any country that has reliable household survey data on:

- The percentage of households experiencing “catastrophic” health expenditures (health spending that exceeds a certain threshold percentage of total or nonsubsistence household spending);
- impoverishing expenditures, measured as the impact of health spending on the “poverty headcount” (number or percentage of households that fall below the nationally defined poverty line as a consequence of their health spending) or “poverty gap” (extent to which households fall below the poverty line as a consequence of their health spending).

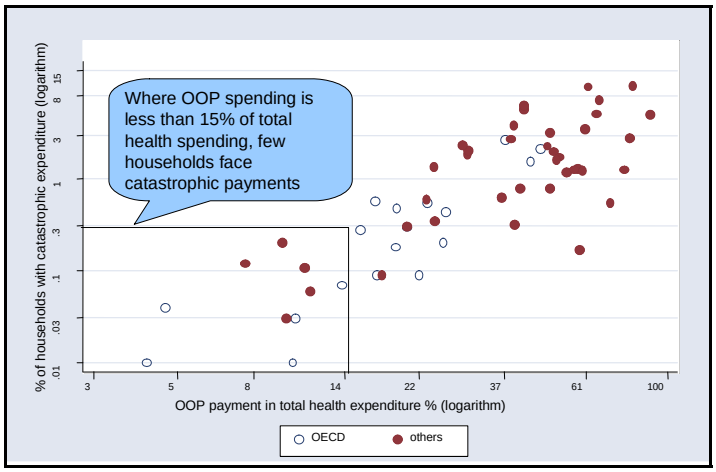
9. Examples of these concepts are shown in Fig. 3. The chart on the left shows the percentage of Estonian households in which out-of-pocket (OOP) health spending exceeded different defined catastrophic thresholds (10%, 20%, and 40%) of total household expenditure in 1995, 2001, and 2002. The chart on the right shows the percentage of households in different income groups that became poor as a consequence of OOP health spending in those same three years.

Fig. 3. Measures of catastrophic and impoverishing health payments in Estonia *(5)*



10. Even without an in-depth analysis of survey data to determine catastrophic and impoverishing effects, international evidence strongly suggests that high levels of OOP spending should be cause for concern. Analysis of data from nearly 80 countries undertaken by WHO *(6)* (Fig. 4) reveals a strong correlation between the share of OOP in total health spending and the percentage of families that face catastrophic[3] health spending.

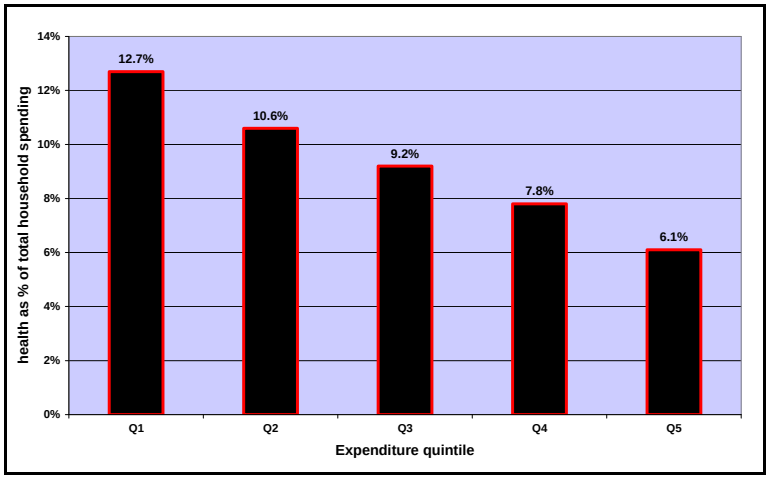
Fig. 4. Proportion of households with catastrophic expenditures vs share of OOP payment in total health expenditure



[3] This analysis uses a catastrophic threshold of 40% of household nonsubsistence income (income available after basic needs, such as food, have been met).

11. A related but distinct objective is that the health system should be ***equitably funded***. This means that, relative to their capacity to pay, the poor should not pay more than the rich. The objective of equity in funding is hence closely linked to the core value of solidarity. In principle, analysis of this should be comprehensive, including all sources of health spending and attributing them back to the households from which they originated, both directly in the form of OOP payments and (voluntary and compulsory) prepayments for health insurance, and indirectly in the form of unearmarked taxation. A full analysis of this requires identifying the various sources of health system funds, analyzing their distributional impact (i.e. who pays), and aggregating these by their relative contribution to total health system funding. International evidence *(7)* strongly suggests that compulsory prepaid sources (general taxation and payroll contributions for compulsory health insurance) tend to be more equitable, voluntary prepaid sources (voluntary health insurance) are less equitable, and OOP payments are the most inequitable. Fig. 5 illustrates inequity in the distribution of OOP health spending in Albania in 2002 *(8)*, where the richest fifth of the population spent about half as much of their income as the poorest fifth of the population. For many countries, therefore, transforming the word "solidarity" into action requires the definition and implementation of reform strategies with specific targets for reducing the share of out-of-pocket payment in total health spending, and in particular, protecting poorer households against such expenditures.

Fig. 5. Inequity in out-of-pocket spending, Albania 2002



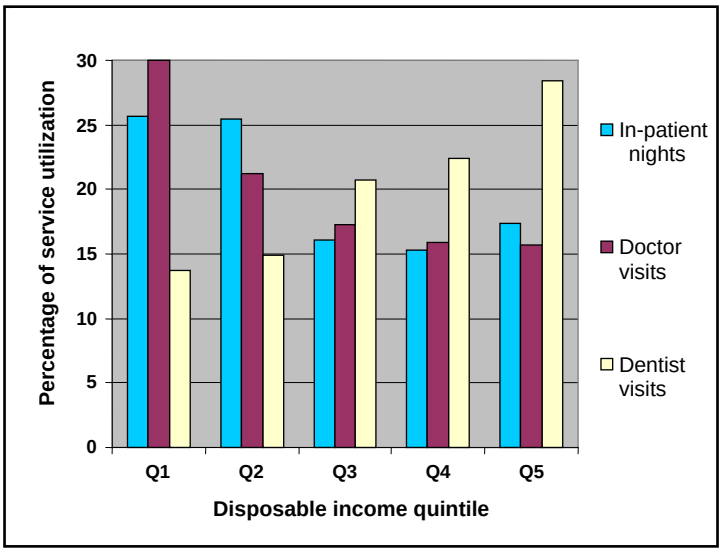
12. Considerations of financial protection and financial equity are not sufficient for an assessment of a country's health financing system, however. The reason is that these financial objectives do not incorporate the effects of the system on people's use of health services. Indeed, because out-of-pocket payment occurs, by definition, at the time of service use, and because this way of paying has harmful consequences for financial protection and financial equity, measures of these policy objectives will show improvement in relation to the extent that poorer people do not use health care.[4] For a sensible policy interpretation, therefore, the impact of the health financing system on the use of services must be considered concurrently with the financial objectives *(9)*.

13. The objective of ***equity in utilization*** can be stated as follows: health services and resources should be distributed according to need, not according to other factors such as people's ability to pay for services. While the financing objectives have to do principally with how money is raised to pay for the health system, the utilization objective has to do (in terms of the contribution of health financing policy) more with how money is spent by the health system. Hence, our concern with equity in the use of services

[4] If poorer people are disproportionately deterred from using services because of their cost, then both utilization and out-of-pocket payments of richer people will comprise a greater share of the total. As a result, household survey data on health spending will show that the financing of the system will appear to be more equitable than if the poor and the rich used the services equally and paid the same amounts.

as an objective calls for equity in the distribution of health spending and resources as a means to pursue this objective. While the objective itself is not hard to understand, consistent measurement is a challenge because there is no routine and low-cost methodology available to provide an objective measure of *need*. Many studies rely on answers to survey questions, and hence try to relate service use to self-assessed health status or self-assessed need. Such measures are imperfect but may have practical application, to the extent that reasonable assumptions can be made about how to interpret data on utilization and need. For example, Fig. 6 summarizes an analysis of survey data from Ireland on the use of different types of health services across the income distribution. The poorest 40% of the population (the two lowest income quintiles) accounted for over half of all hospital nights and general practitioner visits. On the other hand, the opposite pattern is indicated for dentist visits, with over 28% of visits accruing to the richest 20% of the population *(10)*. The "pro-poor" distribution of utilization of general practitioner and inpatient care might be explained by differences in actual need, as well as by effective protection provided by the Irish health financing system against the costs of using these services. Conversely, the pro-rich distribution of dental care use is unlikely to reflect the real needs of the population, and may instead relate more to the presence of charges for dental visits at the point of delivery, which are more likely to deter use by people with lower incomes.

Fig. 6. Shares of service utilization by disposable income quintile in Ireland, 2000



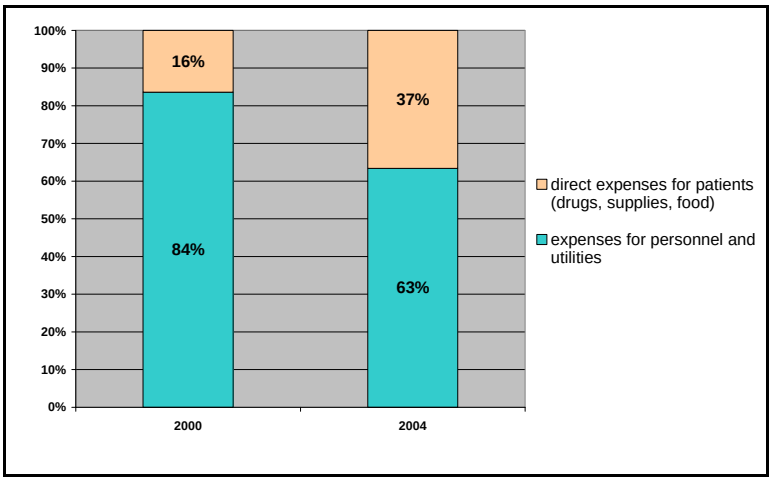
14. The objective of improving ***transparency and accountability*** of the system to the population poses challenges to interpretation and measurement. Therefore, it is useful to put boundaries on this concept to allow it to be used as a practical criterion for the assessment of a financing system or reforms. The key issue here is that the entitlements and obligations of the population should be well understood by all, reflecting a promise by the state to the citizens. In relation to this, there should be periodic reporting by the state to the people on the extent to which this promise is being fulfilled in practice.

15. One specific issue related to transparency for many countries in the Region is the presence of informal payments for health care – direct contributions by patients (or those acting on their behalf, such as family members) made in addition to any payments required by the terms of entitlement, in cash or in kind, to health-care providers for services and related inputs to which patients are entitled *(11)*. The extent of such payments is a direct reflection of lack of transparency because the obligation to pay is not specified yet exists in reality. Reforms aimed at reducing this transparency problem are challenged by the difficulty in identifying and measuring such payments. However, a number of empirical studies on the magnitude of this phenomenon in the European Region and elsewhere have been published, suggesting that developing reliable measures of informal payment is possible *(12)*.

16. Accountability as an objective is difficult to measure but nonetheless important, and certainly open to qualitative assessment. A useful focus is the accountability arrangements for "health financing organizations" such as compulsory health insurance funds or other public agencies that manage the financial resources of the health system. Dimensions of this issue range from (relatively simple) tracking and reporting on financial resources (e.g. audit), to (more complex) reporting on performance relative to some agreed measures, to (most complex) enhancing the legitimacy of the government in the eyes of the citizens *(13)*. An excellent example of "results-oriented accountability" is the annual report of the Estonian Health Insurance Fund, which publishes results of a series of performance indicators related to population satisfaction and awareness of their rights, access to and quality of health services, balance between resources and benefits, quality of customer service, and corporate governance/efficient business practices *(14)*.

17. Financing arrangements should reward good ***quality*** care and provide ***incentives for efficiency*** in the organization and delivery of health services. Success requires that these incentives be aligned with the rules governing service providers, as well as their managerial competencies, to create a coherent and effective environment in which providers are able to respond appropriately to the signals generated by the financing system. For practical policy purposes, we do not attempt to adopt a universally applicable measure to capture these objectives, but instead suggest the use of proxy measures that are country- and situation-specific. For example, contracts introduced in 2003 between the British National Health Service and general practitioners include financial rewards for practices that achieve certain defined targets related to blood pressure and cholesterol levels, while hospital contracts in France specify reductions in the rate of nosocomial infections *(15)*. In the countries of the former Soviet Union, a key focus of efficiency-oriented reforms has been to downsize the physical infrastructure of health systems because of the high fixed costs associated with their maintenance. In this context, a relevant indicator of efficiency is the share of spending devoted to fixed costs associated with the structure of the system (e.g. public utilities, personnel) as compared to spending directly associated with patient treatment (e.g. drugs, medical supplies). An example from Kyrgyzstan is shown in Fig. 7 *(16)*.

Fig. 7. Publicly funded input mix in Kyrgyz hospitals before and after financing reform



18. Promoting ***administrative efficiency*** involves focusing on minimizing duplication of functional responsibility for administering the health financing system. This does not imply a broad agenda of reducing administrative costs; indeed, many such costs are necessary and contribute to the performance of the health system. Hence, the focus should equally be on trying to maximize the cost–effectiveness (in terms of impact on the policy objectives) of administrative functions. The cost–effectiveness of specific administrative functions, such as processes used by a purchasing agency to check the appropriateness of hospital admissions, depends on how well they are performed, and whether responsibility for implementing them is duplicated across several agencies. In some cases, the health financing system itself generates what might be termed "pure costs", in the sense that costs are incurred to implement things that

make no contribution to the performance of a health system. Examples of such costs are the investments made by competing insurers to identify and enrol relatively healthy persons; there is a private return to such investments, but they contribute nothing towards attainment of the policy objectives defined here *(17)*.

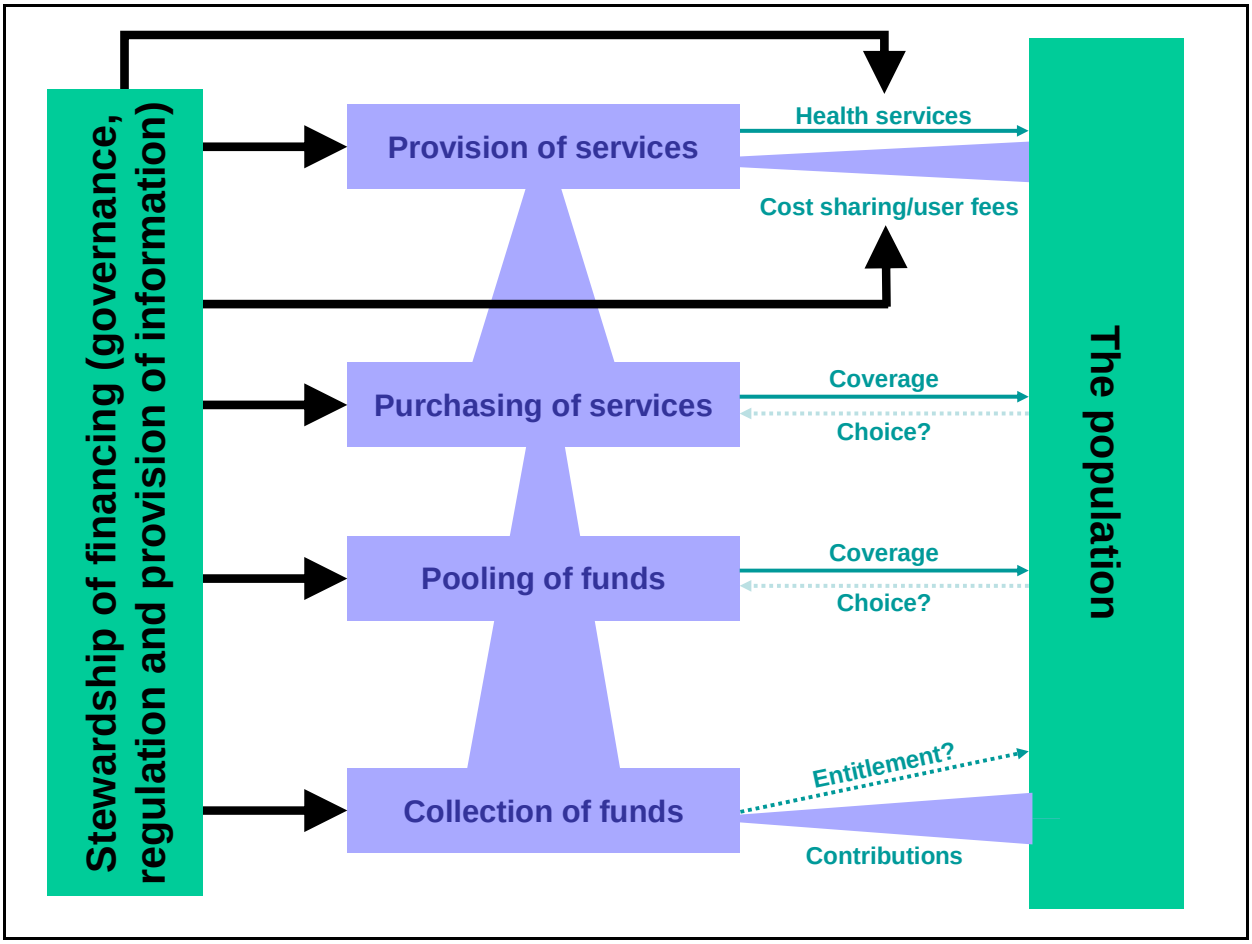
Second pillar: framework for understanding the organization of health financing systems

19. Often, health financing systems are categorized into models or labels (e.g. Beveridge, Bismarck, Semashko). Such labels can be useful to convey important political meanings or to reflect a cultural context in which the health system is considered a "way of life" *(1)*. In many transitional countries, for example, labelling reform as a change to an "insurance system" has been used to transmit a message of change from the former hierarchically controlled health system and economy. Looked at more narrowly through the lens of health financing policy, however, these broad classifications are not very helpful for understanding existing systems or for assessing possible reforms. The models are defined principally by the source of funds (i.e. general budget revenues vs payroll tax revenues), but there is a growing recognition that countries can and have introduced significant reforms to their financing systems without altering the source of funds. Conceptually, the source of funds need not determine the organization of the sector, the mechanisms by which resources are allocated, or the precision with which entitlement to benefits is specified. Spain provides an example of how a transition from a system funded principally from employer/employee contributions to one funded mostly from general tax revenues did not alter the relationship between the population and the health system (*18)*.[5] Alternatively, the Republic of Moldova introduced a payroll tax and compulsory health insurance fund in 2004, but most of the insurance fund's money comes from transfers from general revenues *(19)*. Hence, not only are labels like "tax-funded systems" or "social health insurance systems" conceptually inadequate, such ways of thinking about health financing systems may in fact restrict consideration of possible policy choices or focus attention on the success or failure of particular schemes rather than on their impacts for the system, and population, as a whole *(17)*.

20. To describe the various health financing systems and reforms that have been introduced in the Region, the framework we use[6] integrates the various health financing *subfunctions* and policies depicted in Fig. 8 – revenue collection, pooling, purchasing, and policy on benefits and patient cost-sharing (coverage decisions) – and makes explicit the interactions between these, how they relate to service provision, how they relate to the population and, in addition, their relation to the "stewardship of financing". This latter concept is operationalized as the governance arrangements for the agencies that implement the subfunctions, as well as the provision of regulation and information to enable the system to deliver better results. In that sense, each subfunction can be thought of as a market, with governance, regulation and information essential for aligning these markets with socially desirable outcomes. The approach supported by this framework thus promotes a comprehensive view of a health financing system, facilitating an emphasis on the interactions between different parts of the system rather than a narrow focus on particular reform instruments. This is useful for avoiding emphasis on "magic bullets" (i.e. single reform instruments) that rarely succeed in attaining policy objectives.

[5] Specific groups of previously "uncovered" populations, such as footballers, nuns and others, were incorporated into the system but, for the bulk of the population, there was no change in coverage or entitlements.
[6] This is an extension of an earlier approach *(17)*, which itself is derived from earlier frameworks that emphasized a functional approach to health financing and health systems *(20, 21, 22)*.

Fig. 8. Conceptual framework for understanding the organization of health financing systems (adapted from *(17)*)



21. The subfunctions, policies and relationships depicted in Fig. 8 are common to (even if not explicit in) all systems, whether Beveridge, Bismarck, Semashko or somewhere in between. Detailed knowledge of each of the "boxes" and "arrows" is essential for an understanding of the existing health financing system of a country and, in combination with an assessment of system performance in terms of the achievement of the policy objectives described earlier, for an initial identification and assessment of options for reform. The framework provides a tool for policy-makers and analysts to manage these details: a "checklist" of functions and relationships that must be considered for a comprehensive and effective approach to health financing policy and reform.

22. The analysis begins with the central column of Fig. 8, reflecting the health financing subfunctions and the relation of each with the population. We then move to the stewardship of the financing system. The figure is generic and can be adapted to a wide variety of contexts. Much of that diversity has to do with different mixes of organizational integration or separation of functions (e.g. integration of collection, pooling and purchasing, as is common with much private insurance, or integration of purchasing and provision, as in some public systems and some private health maintenance organizations). Understanding the extent of monopoly or competition in the implementation of a particular subfunction (the "horizontal market structure"), as well as the nature of integration or separation across the functions (the "vertical market structure"), is essential to understanding the overall system.

23. The subfunction of ***revenue collection*** combines consideration of the agencies that collect money, the contribution methods used and the initial funding sources. The connection between collection and the population derives from an obvious but often neglected fact: the population is the source of all funds (apart from funds received from other countries or external aid agencies). Government is not a "source"

but collects tax revenues from the people. Hence, the categories typically used to classify funding sources actually refer principally to contribution mechanisms: general (i.e. unearmarked) tax revenues, payroll tax revenues that are usually earmarked for compulsory health insurance (often called "social health insurance contributions"), voluntary prepayment (usually for voluntary health insurance) and direct out-of-pocket payment at the time of service use. A critical issue is whether or not there is a connection between contribution and entitlement (the dotted arrow from "collection" to "the population" in the figure). In some systems, there is such a connection (e.g. where contributions are made by or on behalf of individuals, and these people are entitled to benefit because this contribution has been made), whereas in others, entitlement is a condition of citizenship or residence. The presence or absence of this contribution-entitlement link is the one important conceptual distinction between a so-called "social health insurance system" and a so-called "tax-based system".

24. In its most generic sense, ***pooling*** of funds refers to the accumulation of prepaid revenues on behalf of a population. Funds for health care are pooled by a wide variety of public and private agencies, including national health ministries, decentralized arms of health ministries, local governments, social health insurance funds, private for-profit and not-for-profit insurance funds, and community-based nongovernmental organizations. Agencies that redistribute funds between pools (e.g. for risk-adjusting the premium income of competing insurance funds) also provide a pooling function. Changes in the way that funds are accumulated can affect not only the extent to which people are protected against the financial risk of using health care, but also equity in the distribution of health resources, the ability of systems to provide incentives for efficiency in the organization of service delivery, and efficiency in the overall administration of the health system. Hence, it is useful to consider not only the objective of risk pooling for financial protection, but also how pools might be reorganized to facilitate progress on other policy objectives. As with other aspects of the system, understanding the market structure of pooling is essential. A key dimension of this is whether there is competition or monopoly: are people able to choose their pooling (insurance) agency or are they assigned to it on the basis of geography or occupation. Other important aspects of market structure are whether there is a single national pool or multiple pools, and whether (in the case of multiple noncompeting pools) these are territorially distinct or overlap with each other.

25. ***Purchasing*** refers to the transfer of pooled funds to providers on behalf of a population. Together with pooling, and as reflected in the arrows in Fig. 8, purchasing enables coverage to be provided for individuals. In other words, funds are pooled and services purchased on behalf of some or all of the population. Key issues in purchasing have to do with the agencies that implement this subfunction, the market structure of purchasing, and the mechanisms used to purchase. Agencies and market structure issues are very similar to pooling since, in most countries, the same agencies that pool funds also purchase services (with the exception of agencies responsible only for redistribution of funds to other pools). Many reforms in the Region have focused on how agencies purchase services, emphasizing incentives to improve the quality and efficiency of service delivery. Many different mechanisms are used to try and purchase services *strategically*, but such measures base at least some of the allocation of funds to providers on *information* regarding their performance or the health needs of the population. Specific mechanisms involve changes in the way that providers are contracted and paid in order to change incentives and create specific conditions related to quality or efficiency gain. Associated with this may be retrospective administrative procedures to check on the quality and appropriateness of care or, at a minimum, to detect fraudulent reporting *(23)*. In contexts with multiple competing purchasers, organizing a coherent incentive environment and minimizing unproductive administrative expenses for providers pose major regulatory challenges.

26. Policy on ***benefits and patient cost sharing*** (e.g. co-payment) entails perhaps the most direct connection between the health system and the population. In this regard, it is helpful to think of the benefit package as those services, and means of accessing services, that the purchaser(s) will pay for from pooled funds. This definition implies that what is not in the package (fully or partially) must be paid for (fully or partially) by patients, within or outside the publicly funded system. This makes explicit the link between benefits and cost sharing (i.e. partially covered services are subject to cost sharing), and moves these policies into the integrated health financing policy framework and away from being isolated

measures to ration services, raise extra revenues, or deter demand. By including "means of accessing" in the definition, the benefit package can be seen as one of the instruments available to steer utilization in a desired manner (e.g. making entitlement to specialist care dependent on the obligation to be referred from primary care).

27. A range of issues and considerations arise when considering the (re)design of benefit packages. Attention is typically focused on deciding what services to include for coverage, along with attempts to balance technical approaches for population health needs assessment *(24)*, technology assessment, and the cost–effectiveness of interventions *(25)*[7] and the need to involve citizens and advocacy groups *(26)* in the process. While such efforts are essential, in some cases the emphasis on the technical aspects of benefit package design can lead to a loss of focus on the basic objectives of the package and its connections to overall health financing policy. In particular, the package is most closely related to the objective of promoting transparency in the entitlements (i.e. the services available) and obligations (i.e. the rules that must be followed to obtain the entitlements, e.g. paying co-payment, following defined referral channels, etc.). A prerequisite for success, therefore, is that people understand their entitlements and obligations.

28. Finally, the manner in which ***stewardship*** of the financing system is implemented is all-important. This has to do with the overall design of the system, its governance and the "top-down" support provided to help it function better. In this regard, it is useful to think of the subfunctions and policies described in Fig. 8 as a *market*. In any country (or region of a country), the agencies that supply the subfunction can be characterized as being, for example, competitive, monopolistic, etc. To align these markets effectively with the health financing policy objectives, it is necessary to provide both information and regulation. Examples of information provision include the dissemination, to both the population and the providers, of information on categories of the population and services that are exempt from cost sharing, or the development and dissemination of guidelines to help consumers choose among competing insurers. Examples of regulation include the definition of "open enrolment periods" that allow people to change insurers or primary care providers, or requiring purchasers to obtain a second opinion before denying certain services to patients. Considerations of overall financing system design are closely related to this, and range from the introduction of specific measures, such as a standardized basic benefit package or a risk compensation scheme in the context of competing insurers, to the more general issue of ensuring that the various instruments of financing policy are aligned with each other, as well as with related policies on service delivery.

Third pillar: incorporating fiscal constraints and other contextual factors

29. While countries may share core values and agree to the broad goals of health systems and objectives of health financing policy, there are factors originating from outside the health system that constrain the extent to which different countries can realize these objectives, goals and values in practice. For health financing, the most important contextual issue is the fiscal context. This refers to the ability of the government to mobilize tax[8] and other public revenues, and the need for these to be balanced with total public spending. And, since systems that rely more on public funding tend to do better at attaining objectives such as financial protection, equity in finance, and equity in utilization, the fiscal context is critical, because the more money that government has, the more it can spend on health.

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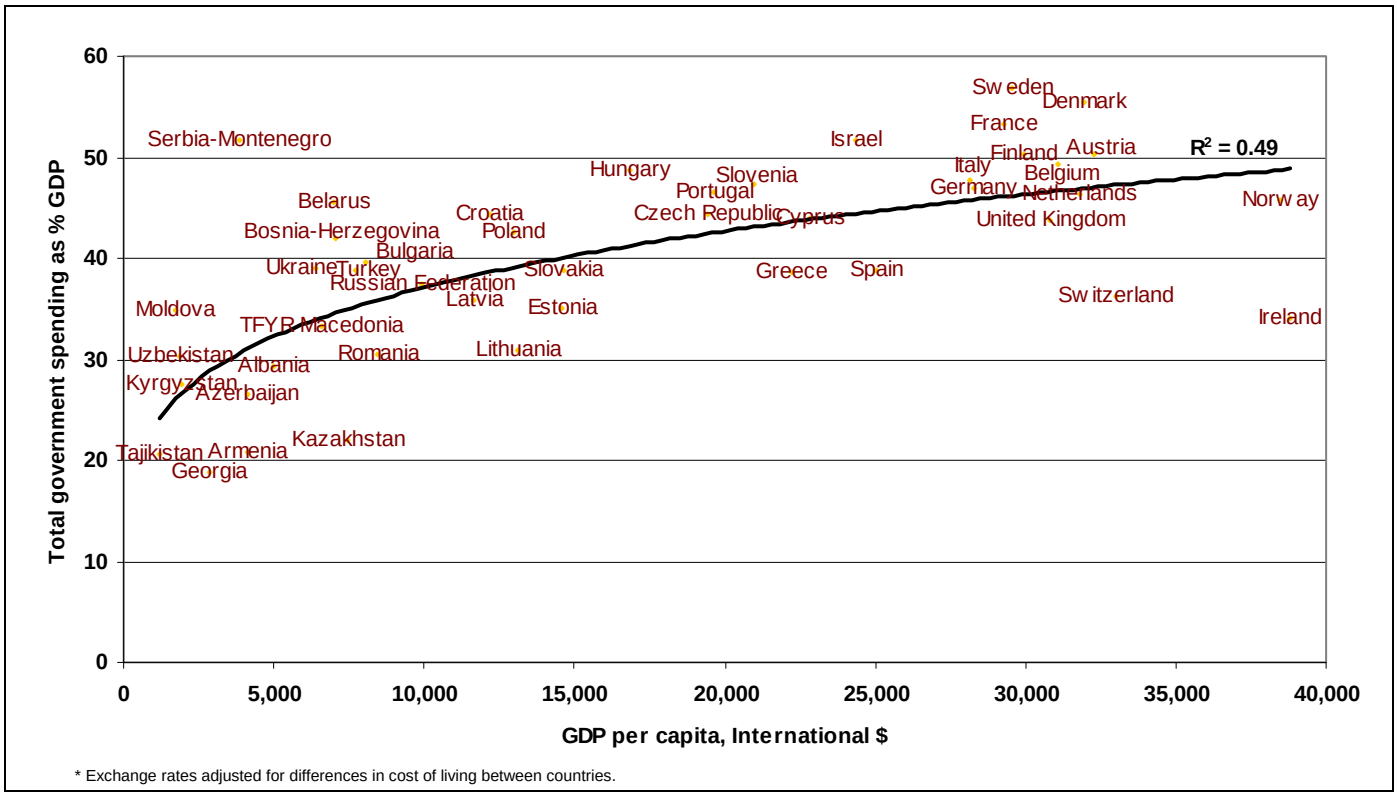
[7] In addition to the WHO-CHOICE tool, there are considerable resources available to support countries in these technical areas. The Centre for Reviews and Dissemination of the University of York maintains the NHS Economic Evaluation Database and the Health Technology Assessment Database (http://www.york.ac.uk/inst/crd/index.htm), containing critically reviewed evidence of economic evaluations of health interventions and health technologies. The International Network of Agencies for Health Technology Assessment (INAHTA) provides a forum for accelerating exchange and collaboration among HTA agencies (http://www.inahta.org/inahta_web/index.asp). Established in 1993, INAHTA presently has 45 member agencies in 22 countries, of which 15 are in the WHO European Region.

[8] This includes all forms of compulsory contributions, such as income and value added taxes that become part of general public revenues, and payroll taxes that are specifically earmarked as social security, including (compulsory) health insurance contributions.

30. A good measure of fiscal context is the ratio of public revenues (or expenditures) to gross domestic product (GDP). In general, richer countries tend to be more effective at mobilizing tax revenues (relative to the size of their economies). Tax collection is usually more difficult in poorer countries because more of the population tends to live in rural areas or work in the informal economy *(27,28)*. As shown in Fig. 9, this relationship between national income and fiscal capacity applies to European Member States. The variation of individual countries around the trend indicates, however, that GDP per capita does not completely determine fiscal context. For example, public spending as a percentage of GDP is about the same in Bulgaria as it is in Spain, even though GDP per capita in Spain is more than three times greater. Similarly, Ireland and The Former Yugoslav Republic of Macedonia have about the same public expenditure-to-GDP ratio even though per capita GDP is over six times greater in Ireland. This further indicates why it is essential to understand the fiscal situation, and not just the level of income, when analysing the context for health financing policy in a specific country.

Fig. 9. Fiscal capacity and national income in the European Region, 2004
(WHO estimates for Member States with population greater than 500 000)



* Exchange rates adjusted for differences in cost of living between countries.

31. Governments must be mindful of their budgetary limits; they cannot simply spend to meet all the needs of their societies. The public sector must be *fiscally sustainable*; expenditures must come into balance with revenues. This applies to health financing systems as well. But *fiscal sustainability is a requirement rather than an objective of health financing policy*; health financing systems should be assessed by the extent to which they attain policy objectives relative to what they could possibly attain, while meeting the obligation for fiscal balance.[9] There is thus a very important distinction between efficiency and fiscal sustainability. Many countries faced with persistent deficits in the health sector are rightly concerned about this problem, but a narrow focus on eliminating deficits may divert attention away from the underlying inefficiencies that were the cause of the problem. In countries in which public hospitals can pass on their deficits to the government, for example, this lack of accountability is a source of inefficient resource management, with deficits as the manifestation of the problem. Some countries faced with this are responding with plans to constrain the benefit package (i.e. increasing patient cost-

[9] This is akin to the distinction between health system attainment and health system performance *(3)*.

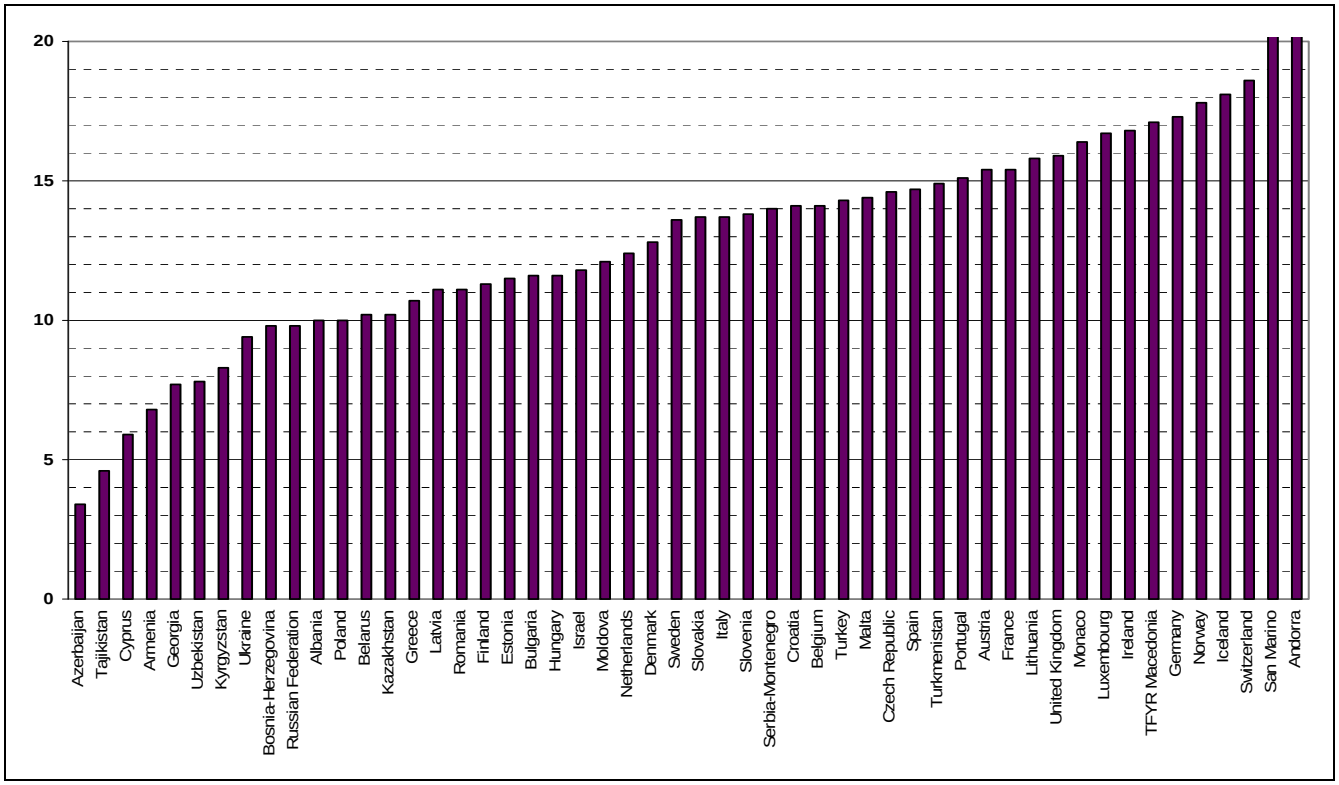
sharing obligations) and expand coverage of complementary voluntary health insurance to cushion the population against these additional payments. Such measures may indeed provide temporary deficit relief but do nothing to address the underlying causes of the problem. As a result, deficits will reappear, while the reforms introduced will have harmful consequences for equity and financial protection (as poorer and sicker people will have a harder time obtaining voluntary health insurance). By treating fiscal sustainability as the obligation to live within a budget, rather than as an objective, policy-makers' focus can shift from an emphasis on deficit reduction to a broader view of addressing existing inefficiencies as a way of minimizing the impact on health system objectives, while meeting the requirement for fiscal balance.

32. Limits on the amount that governments can spend on health imply the need for explicit or implicit rationing that, in turn, means tradeoffs between the attainment of the health financing policy objectives and the need for fiscal balance. The more constrained the fiscal environment, the harsher these *sustainability tradeoffs* will be. But, in an increasingly globalized world, there is and will continue to be downward pressure on tax rates in all countries, including richer countries, as they compete to attract international businesses. The need to address sustainability tradeoffs is thus faced by all countries. The challenge, frequently, is to encourage them to deal with it as an explicit, participatory social decision rather than an implicit result of inaction.

33. Fiscal sustainability is an elusive concept, however. Limits on the ability of governments to mobilize tax revenues from their populations do constrain their ability to spend and, indeed, countries cannot continually run fiscal deficits. Eventually, total public spending has to be brought into line with available public revenues. The *fiscal sustainability of one sector* of public expenditure, such as health, is harder to define, however. The amount that a government spends on health depends in part on its fiscal context and in part on decisions that it makes with regard to priorities. Mathematically, public spending on health as a percentage of GDP is the product of total public spending as a percentage of GDP (government's fiscal capacity) and the share of that spending allocated to the health sector. As shown in Fig. 10, this share, reflecting the priority that governments accord to the health sector,[10] varies widely across the Region.

[10] While it is reasonable to use the share of government spending devoted to health as an indicator of public sector priorities, it is imprecise to say that this percentage reflects purely the priority that governments give to health. A more accurate statement is that it reflects the priority (implicit or explicit) given to putting money into the health sector.

Fig. 10. Health spending as a percentage of total government spending, 2004, Member States in the European Region (WHO estimates)

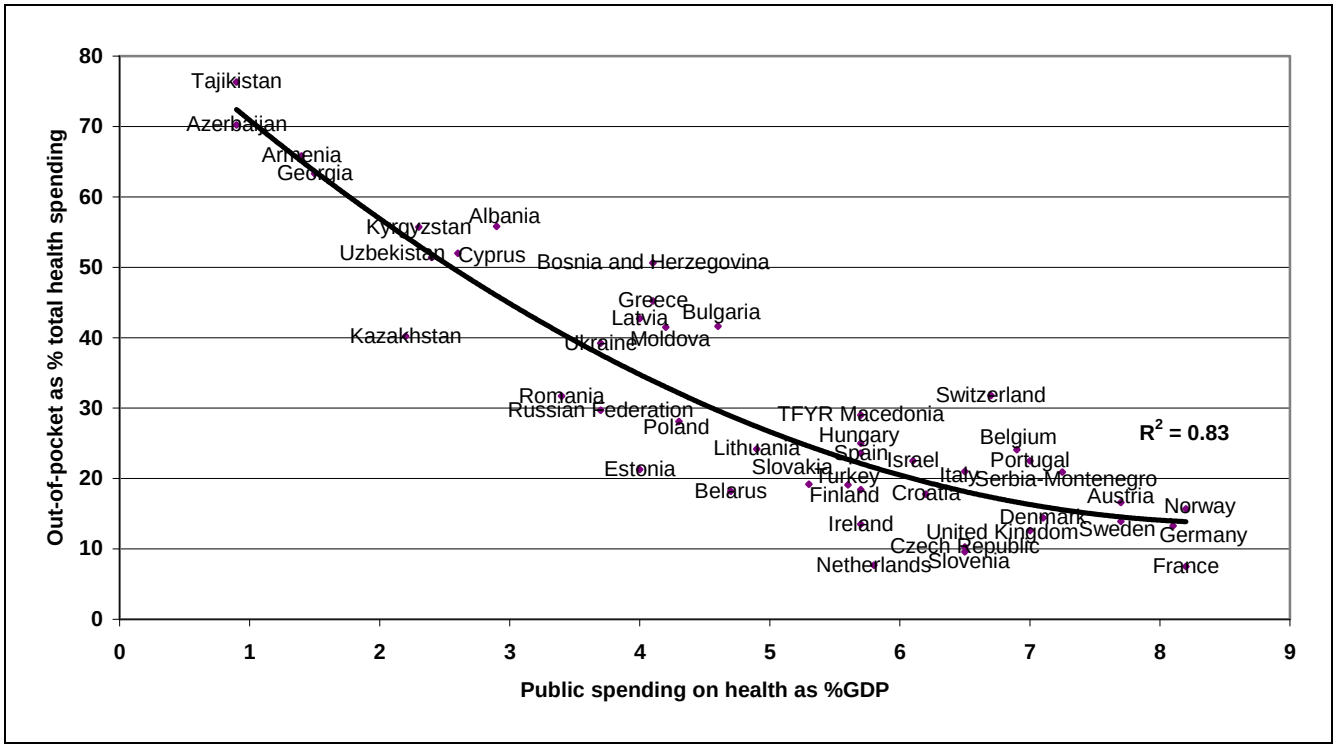


34. Given the overall fiscal constraint, differences in priorities can result in a wide range of government health spending levels as a share of GDP and this, in turn, can have important consequences in terms of health finance policy objectives. In Estonia, for example, public spending on health declined from 5.9% of GDP in 1996 to 4.1% of GDP in 2003. This was partly due to an overall fiscal contraction, with total public spending falling from more than 42% of GDP to slightly less than 37% of GDP over this period. At the same time, health spending fell from 14% to 11.2% of total public spending. Had the same 14% share of public spending been maintained, government health spending would have been 5.1% of GDP in 2003. Beyond this, it is notable that the share of out-of-pocket spending in total health spending rose from 11.5% to 20.3%.[11] This country-specific example suggests that the ability of the Estonian health system to sustain a lower burden of out-of-pocket spending (and hence better financial protection – recalling the growth in catastrophic and impoverishing spending over this same period shown in Fig. 3 – and access to care) was reduced mostly by "choice" and only partly by overall fiscal constraints.

35. Analysis of health spending data from the Region (Fig. 11) illustrates the strong inverse relation between (a) government spending on health as a percentage of GDP, and (b) the share of total health system spending coming in the form of out-of-pocket payments. In other words, the more governments spend on health, the less patients pay at the time they use services, with consequent implications for the objectives of financial protection, equity in finance, and equity in the use of services. Of course, there is variation around the trend, indicating that the level of public spending does not determine everything; health financing policy matters. But it is nevertheless evident that the level of public spending on health, driven partly by fiscal constraints and partly by government priorities, has important implications for the potential of countries to attain their policy objectives.

[11] All the data cited here are taken from the WHO estimates of country health expenditures (http://www.who.int/nha/country/en/).

Fig. 11. Relation between the level of government health spending and the share of total spending coming from out-of-pocket payments in the European Region, 2004
(WHO estimates for Member States with population greater than 500 000)



36. The evidence cited above demonstrates that, while fiscal limits matter, priorities also matter and, to some extent, the level of health spending that governments can "sustain" is a ***decision*** rather than purely a feature of the wider economic and fiscal context. However, this example does not imply that we should simply advocate larger allocations to health. We have suggested that fiscal sustainability is not an objective of health financing policy; similarly, increasing the level or share of government health spending is also not an objective of health financing policy. Any such increases must be justified by the ability of the health system to turn increased revenues into increased attainment of objectives. Most importantly, recognition of both existing and likely future fiscal pressures facing all countries leads us to conclude that health systems must give increased attention to improving the ***efficiency*** of resource use. There is no excuse for not attempting to get the most (in terms of progress on policy objectives) from the public resources that are spent. While there will never be enough funds to satisfy all the needs of a health system, making better use of the resources that are available is the principal means to lessen the severity of sustainability tradeoffs.

37. Beyond fiscal concerns that are relevant in all countries, other contextual factors can affect health financing policy. Each country has its specificities, and we can not address all possible contextual factors here. We focus on three: demographic structure and projections; rules governing the wider public finance system; and political-administrative decentralization.

38. The current and projected future demographic structure of a country has important implications for health financing policy. There are two dimensions to this. First, older populations tend to need and demand more health services. Therefore, countries with an older population structure, or where rapid aging is projected (as in many Member States in the European Region that have low fertility and low mortality), are likely to have (or face in the near future) upward pressure on system costs as a result. Second, where populations are aging and fertility is low, the size of the productive workforce declines relative to the rest of the population, unless the gap left by falling fertility is filled by immigrant labour. This has important implications for the mechanisms that can be used to collect revenues for the health

system *(28)*. The first dimension suggests the need for policy-makers to create a comprehensive, systematic response, including some changes to the way that priorities for health spending are set and, perhaps more importantly, strategies to reform service delivery and measures to promote healthy aging, as well as to strengthen coordination between health and social care. The second dimension is particularly important for those countries that currently rely heavily on employment-related contributions (e.g. payroll taxes for compulsory health insurance) to fund their systems. As the share of the working-age population shrinks in relation to the total population, it will become essential to diversify public funding sources to provide coverage for the noncontributors. Indeed, it is already true that, in most west European countries with social health insurance schemes, public funding does not come solely from wage-based taxation. Only Germany and the Netherlands cover more than 60% of total health spending in this way. In Austria, Luxembourg and Belgium, less than half of total spending is funded from payroll taxes *(29)*. Hence, the diversification process has already begun. As demographic change proceeds, diversification will continue, and indeed more fundamental reforms to de-link health coverage from employment status may be needed to sustain high levels of financial protection and equity.

39. The public finance context involves understanding not only the capacity of the state to mobilize tax revenues, but also how the wider public sector management system operates. This encompasses areas such as civil service regulations and the rules governing public sector financial management. The system can provide an *incentive environment* that allows health financing reforms to have their intended consequences, or, conversely, it may inhibit implementation of certain health financing reforms or provide a set of perverse incentives that cause reforms to have undesired consequences. There is no inherent reason why the objectives of public sector management reform, such as improved accountability for the use of public funds, cannot be made consistent with health financing reforms aimed at improving efficiency through strategic purchasing of services and increased financial autonomy for facility managers. This requires effective communication between those leading health financing reforms and those responsible for reforming the wider public sector.

40. A third critical contextual factor for health financing policy is the extent of political-administrative decentralization in a country. In decentralized countries, such as Bosnia and Herzegovina, Sweden and Switzerland, the organization of health financing systems mirrors the organization of government administration, resulting in decentralized pooling arrangements. This is undesirable because smaller pools offer less capacity for cross-subsidy and hence for financial protection afforded by a given level of funding. Further, where public provision is also fragmented, the result can be inefficiency in the form of excess capacity. This is clearly a problem in the Swiss *(30)* and Bosnian *(31)* settings, where the extent of political decentralization is such that the ability of central government to compensate for variations in revenue generation is limited. In Sweden, country councils and municipalities pool funds and purchase services, but the entire system works virtually as a single pool through the implementation of a resource allocation formula and direct central government allocations to local authorities *(32)*. In each case, what might be “best” is constrained by contextual factors that drive what it is possible to implement.

41. The above and other contextual factors must be taken into account when considering health financing policy in any particular country. While it is certainly useful and necessary to learn lessons from the experience of other countries, policy instruments can not simply be transplanted from one country to another. The critical issue for national policy-makers is to identify and understand how factors outside the health system constrain what can be attained and what health financing reforms can be implemented.

Critical challenges for policy: fragmentation and alignment

Recognizing, reducing or addressing the consequences of fragmentation

42. Fragmentation of health financing arrangements is problematic in many ways; hence, an important policy concern in many countries is to reduce or eliminate it. The objectives of financial protection and access to care are best served by risk pooling arrangements that maximize the potential for cross-subsidizing from the healthy to the sick; the larger the pool (or put another way, the smaller the number of

pools per population size), the greater the amount of risk protection (cross-subsidy) that can be provided. In Germany prior to 1996, the "starting point" for reform was multiple sickness funds to which people were assigned according to occupation. This fragmentation, combined with the ability of the funds to set their own contribution rates, caused inequities in funding the system, as the amount that people had to contribute was associated with the riskiness of their occupational category rather than their ability to contribute. Pooling reforms combined giving all workers the right to choose their fund with a mechanism that transfers money between funds to compensate those with higher-risk members (the "risk structure compensation scheme"). These reforms led to a reduction in the differences in contribution rates between funds *(33)*. While multiple funds remain, this redistribution mechanism has effectively reduced fragmentation by creating a "virtual single pool" among the sickness funds.

43. Fragmentation can also promote inefficiency in the organization of service delivery. In the health financing system of the former Soviet Union, for example, funds were pooled at each level of government (republic, *oblast*, *rayon*/city), and these pools were vertically integrated with both purchasing and service provision through a hierarchical line-item budgeting process. Further, because *rayons*/cities exist within *oblasts*, these compulsory pools overlapped and, in turn, duplicated service coverage for the people who were residents of both the city and the oblast. These organizational arrangements for health financing and service delivery, combined with the incentives of the input-based budgeting process, contributed to the extensive physical infrastructure of the Soviet medical system. From this context, addressing the problem of excess service delivery infrastructure has required reform of the financing system in order to create a single pool for the entire population of a geographic territory, and separation between the finance and delivery systems (i.e. ending the line-item budget process). These reform steps have been prerequisites for reducing inefficiency by down-sizing service delivery systems in Kyrgyzstan *(34)* and the Republic of Moldova *(19)*.

44. Problems and challenges also arise from fragmentation in financing arrangements between the "general" health system and other types of services and programs, such as social care and vertically organized disease control programs. In the Netherlands, there is long-term care insurance (AWBZ) for the entire population. It is separate from the insurance funds that compete to manage the main (acute care) benefit package for personal health care services in the country, though both AWBZ and the insurance funds are regulated by the Ministry of Health. Competition between the insurance funds leads them to try to reduce their costs, and one unintended consequence of this is that they try to shift costs (and patients) to the AWBZ system. Because this has had detrimental effects on the continuity and effectiveness of care, *(35)* the government has made explicit its intention to address the problem.

45. Fragmentation in financial arrangements for vertically organized tuberculosis, HIV/AIDS, and drug abuse programmes in most east European Member States creates disincentives to joint planning and contracting, even though many of the clients and risk groups for the interventions delivered by these programs are the same. Fragmentation arises from the historical practice of "funding programs", i.e. giving budgets to programs that independently purchase or deliver their own set of interventions for *their* disease/condition. This is a source of inefficiency because it inhibits, for example, coordination by the HIV and drug abuse programmes of the packaging of their interventions (e.g. blending needle exchange or substitution therapy with condom promotion), even though the two programmes serve largely the same population groups *(36)*. There is an urgent need, therefore, to address the fragmented financing arrangements for these programmes in order to allow a shift to a more efficient *client-oriented* system.

Aligning reform instruments with policy objectives

46. A key policy challenge is to ensure that the instruments of health financing are aligned with each other and with the objectives that are meant to be achieved. Lack of alignment can cause policies to be ineffective or actually harmful. An example that arises in many countries is a mismatch between reforms in purchasing and the governance arrangements for public sector health facilities. For example, it may be ineffective to change the way in which public sector facilities are paid if their managers do not have the right to make autonomous financial management decisions (i.e. if they do not have the right to shift funds across predefined budget line items). Similarly, the introduction or refinement of provider payment

methods designed to shift financial risk to hospitals (e.g. payment of a fixed amount per case) are likely to be of little value if the providers can avoid this pressure. This has been the experience of Croatia *(37)* (where publicly owned providers can pass their deficits on to the fiscal deficit), Poland *(38)* (where public hospitals can roll over their debts from one year to the next) and Switzerland *(30)* (where publicly owned health facilities face a "soft budget constraint", with local governments covering their deficits at the end of the budget period). Addressing the underlying causes of problems in the performance of health financing systems requires coherence between the strategies used to purchase services and the organizational and governance arrangements for service provision.

47. An overemphasis on the design of a particular reform instrument may also result in misalignment unless equal attention is given to the policy objectives that the instrument is meant to support. For example, while development of a credible benefit package requires detailed work to estimate the expected cost of services and compare this to expected revenues, it is essential that the results of these calculations be *translated* into a package that the average person can understand. So, rather than a long list of interventions or diagnoses, the package should enable someone to know, for example, that they are entitled to visit their family doctor with a co-payment of €1 but that if they go directly to a specialist they will have to pay much more. In other words, the structure of the package, and the way it is communicated to the population, should be aligned with the objective of improving transparency of the system to the population. Evidence from the Region demonstrates that, when a package is very complex, changes frequently, or is grossly inconsistent with the revenues available in the system, informal payments for care can become widespread *(39)*. Countries should aim to create a benefit package *process* that evolves over time as clinical practice develops, technology changes, data improves, and the relative importance of different objectives changes. Ongoing monitoring and evaluation of the implementation of benefit packages is essential; in many countries, important tools for this are patient surveys to determine changes in the extent and magnitude of informal payments.

Conclusions: principles and practical steps for policy-makers

48. The approach to health financing policy suggested here embodies certain core principles and concepts outlined below.

- As with all aspects of health policy, it is essential to make a clear distinction between the objectives of health financing policy (e.g. improving financial protection, improving access to care) and the instruments of health financing policy (e.g. creation of an insurance scheme, reform of provider payment methods, etc.). Related to this, the analysis of proposed and implemented reforms should focus on the effects on the population and system as a whole; schemes are not systems.
- Given this first principle, it should be understood that all health financing systems (other than pure out-of-pocket payments) are systems of ***insurance***, and should be assessed by how well they achieve related objectives for their populations (i.e. financial protection, equity of access, etc.), rather than according to the label or model that is generally applied to their system. For example, German citizens are not somehow more "insured" than British citizens simply because the German system is labelled as "insurance" while the British system is not. Correspondingly, and while noting that labelling can be very important in particular national/political contexts, it is essential that health finance decision-makers should not let the label that is applied to their system limit consideration of the available policy options. There is no conceptual reason why the source of funds should determine how they are pooled, how services are purchased, or the detail with which benefit entitlements are specified.
- A clear focus on the policy objectives should be combined with a deep understanding of the existing organization of health financing functions and policies, and of the fiscal and other contextual factors that condition the feasibility and expected effects of different policy options. Reforms should be oriented to the policy objectives, and the descriptive framework used as a "checklist" to ensure that reform instruments are ***aligned*** with the desired objectives.

- Current and expected future fiscal pressures imply that all countries must redouble efforts to improve the ***efficiency*** of their health (financing) systems. Efficiency is not synonymous with fiscal sustainability; hence, promoting efficiency does not imply a narrow focus on cutting budgets. Instead, it suggests a broad approach to ensure that whatever is spent on health yields the greatest return, in terms of progress on policy objectives, given the reality that spending must be in line with available resources. Related to this, conditions (incentives) in the wider public finance environment should allow the benefits (i.e. savings) from any efficiency gains made to be retained by the health system and used to improve its performance.
- Implement, evaluate, learn, and adapt: health financing reforms, like health reforms more generally, should be designed using a strong conceptual and evidence base, while recognizing that not everything can be planned; there will always be a degree of uncertainty in terms of both implementation and results. Hence, policy reform is as much art as science, and decision-makers should, where feasible, facilitate learning through implementation and evaluation of pilots. It is essential for every country to institutionalize reform evaluation mechanisms, thereby enabling an adaptable health policy process to build on knowledge generated from its own reform experience. It is also important and extremely valuable for countries to learn from the experience of others. Because each country has its own context and starting point for reform, however, it is equally important to recognize that policies can not simply be transplanted from one country to another.

49. Although it is not possible to reduce health financing policy, nor overall health policy, to a narrow, technocratic formula, the "three pillars" provide a guide to decision-makers on how to approach health financing policy in their own national context. Key steps include the following:

- using the health finance policy objectives as a guide to identifying a country-specific set of problems and priorities with regard to the performance of the health financing system;
- accepting that "the devil is in the details" when it comes to making effective health financing policy. A thorough analysis should be made of the existing system of health financing, using the descriptive framework to provide a "checklist" to ensure consideration of each subfunction, all resource allocation mechanisms, policies on population entitlements and obligations, and the stewardship arrangements for the system as a whole. These arrangements should be mapped, including the flow of funds, the extent of vertical integration or separation of functional responsibilities, and the market structure within each subfunction, as a useful tool for understanding the existing health financing system – the "starting point" for any reform program. The critical functional areas where policy instruments are misaligned should be identified;
- analysing the fiscal context in collaboration with the finance ministry, using historical data on public revenues and expenditures, as well as projections of likely scenarios;
- identifying and analysing all other contextual factors from outside the health system that might have implications for the implementation or consequences of particular reform options;
- developing a set of reform options oriented to addressing the priority performance problems or objectives of the system. The descriptive framework should be used as a guide to ensure a comprehensive approach from the current starting point and to avoid the temptation of "magic bullet" solutions that emphasize just a single reform instrument. The objectives and proposed options should be checked against the fiscal situation to ensure that these are realistic to the national context;
- facilitating informed public dialogue with regard to the nature of the system's objectives and problems, as well as the options for reform. Popular expectations that everything will be provided for everyone should be managed by disseminating the concept of sustainability tradeoffs, and hence the need for some form of rationing. No solution will satisfy everyone, but the choices and tradeoffs should be made explicit;
- taking advantage throughout the process of the reality that every country in the world is struggling with how to reform its health financing system. These experiences should be learnt from and particular lessons adapted to the national context.

50. In conclusion, we wish to emphasize that WHO has no model or blueprint for how health financing systems should be organized. Instead, the approach we propose to Member States is this: (1) use the policy objectives to orient the ***direction*** for health financing reforms; (2) understand the existing system in terms of functions and policies to set the ***starting point*** from which any reform must begin; (3) understand the fiscal and other contextual factors to establish ***realistic limits*** on the extent to which the attainment of policy objectives can be ***sustained***, and the range of policy reforms that can be considered. Hence, while the approach is fundamentally grounded in a common set of values and goals, it also allows for analysis and recommendations that are country-specific and realistic. More generally, WHO is committed to the objectives of health financing policy, but we are not committed to any particular organizational form or model.

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